Requester: Fill Out to Receive Requested Information Expeditiously.

Notify: Supervisor
Location: SAIL Dept.

NOTE: THIS FORM IS TO BE USED TO **OBTAIN** MEDICAL RECORD INFORMATION **FROM** OTHER AGENCIES.

| | | Date of Birth |
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| I hereby request and author | rize: | |
| | | |
| to release information to: | Milwaukee County Behavioral Health Division 9455 Watertown Plank Road Milwaukee, WI 53226 | |
| The purpose for releasing th | nese records is | |
| | nation may include diagnosis, prognosis, and/or tre and/or AIDS-related diagnosis. | atment for physical illness, mental disorders, alcohol or drug |
| The specific and relevant inf | formation I wish to release is: | |
| Discharge Sumr | naries | Treatment Plans |
| PCS Intake | | Lab/Radiology |
| History & Physic | al | Outpatient Assessments/Evaluations |
| Psychiatric/Psychological Evaluations | | Outpatient Progress Notes/Treatment Plans |
| Social Service D | ata Bases | Other (specify) |
| for the treatment period of (li | st approximate dates): | |
| | des this seasons of our times by uniting a settingtion | |
| any event, this consent | | |
| any event, this consent here | | |
| any event, this consent here A photocopy or facsimile of the PROHIBITION ON DISCLOSI rules prohibit making any furtipertains or as otherwise perm Federal rules restrict any use | will expire one year from the date of signal is authorization shall be as valid as the original. URE (for Alcohol and Drug Abuse records): This information unless further discipled by 42 CFR, Part 2. A general authorization for the information to criminally investigate or prosections. | mation is protected by Federal confidentiality rules (42 CFR, Part 2). The Federal closure is expressly permitted by the written consent of the person to whom it ne release of medical or other information is NOT sufficient for this purpose. The |
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BEHAVIORAL HEALTH DIVISION Milwaukee, Wisconsin 53226

| Patient's Name | | Date of Birth |
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| I hereby request and authorize: | Milwaukee County Behavioral Heal 9455 Watertown Plank Road Milwaukee, WI 53226 | th Division/SAIL |
| to release information to: | | |
| | | |
| The purpose for releasing these | records is | |
| I understand that the information abuse, any HIV test results and/ | | and/or treatment for physical illness, mental disorders, alcohol or drug |
| The specific and relevant information | ation I wish to release is: | |
| Discharge Summarie | es | Treatment Plans |
| PCS Intake | | Lab/Radiology |
| History & Physical | | Outpatient Assessments/Evaluations |
| Psychiatric/Psycholo | gical Evaluations | Outpatient Progress Notes/Treatment Plans |
| | _ | |
| Social Service Data I | Bases | Other (specify) |
| | | Other (specify) |
| for the treatment period of (list ap I understand that I may revoke th | oproximate dates):is consent at any time by written notifi | |
| for the treatment period of (list ap I understand that I may revoke th and that in any event, this consen here | oproximate dates):is consent at any time by written notifi | cation except to the extent that action has been taken in reliance on it signature unless an otherwise stated date, event or condition is stated |
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NOTE: THIS FORM IS TO BE USED TO RELEASE MEDICAL RECORD INFORMATION FROM THE BEHAVIORAL HEALTH DIVISION

BEHAVIORAL HEALTH DIVISION Milwaukee, Wisconsin 53226